

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 13134 CERTIFICATE OF DEATH

13128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seabrookville, P.T.D.</i>		c. LENGTH OF STAY IN 1b <i>20 yrs.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Worcester</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seabrookville, P.T.D.</i>		d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Carrie Griffin Cater</i>		First <i>Carrie</i>	Middle <i>Griffin</i>	Last <i>Cater</i>	4. DATE OF DEATH <i>Nov. 12 1958</i>	Month <i>Nov.</i>	Day <i>12</i>	Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1898</i>	9. AGE (In years lost birthday) <i>60 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	13. IF UNDER 24 HRS. Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Portsmouth, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Dan Simpson</i>		14. MOTHER'S MAIDEN NAME <i>Martha Puddick</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Harold Cater, Seabrookville, Del.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>443X</i>		DUE TO <i>Congestive Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i></i>		(b) DUE TO <i>Hypertension, Cardiovascular Disease</i>		3 1/2 hrs					
(c) <i>Pneumonia</i>				3 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>49-X</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Berlin, Md.</i>	(County) <i>Baltimore Co.</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>5/2 1955</i> to <i>11/12 1958</i> that I last saw the deceased alive on <i>11/12 1958</i> , and that death occurred at <i>7:45 PM</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Henry S. Sully, Jr. M.D.</i>		ADDRESS (Street, city or town, state) <i>Berlin, Md.</i>						DATE SIGNED <i>11/17/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/16/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Anne Arundel Cem.</i>		22d. LOCATION (City, town, or county) <i>Anne Arundel Co., Md.</i>			(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Watson</i>		ADDRESS <i>Pocomoke City, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 18 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

CERTIFICATE OF DEATH

1998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 13135

13129

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Shoreham</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Showell</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Life</i>		d. STREET ADDRESS <i>Showell Md</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>James B Collins</i>		First <i>James</i>	Middle <i>B</i>		
4. DATE OF DEATH <i>Nov 1 1958</i>	Month <i>Nov</i>	Day <i>1</i>	Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 2-1884</i>		
9. AGE (In years lost birthday) <i>74 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	12. BIRTHPLACE (State or foreign country) <i>Md</i>		
13. FATHER'S NAME <i>Edward J Collins</i>	14. MOTHER'S MAIDEN NAME <i>Mary Lockwood</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>X</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Charlie F Collins</i>	Address <i>Showell Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>150 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO <i>Carcinoma of esophagus c</i> <i>Secondary metastasis</i> <i>Cachexia & anasarca</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>1-2 yrs</i>					
6 mo.					
1 mo					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov</i> , 1958, to <i>Nov</i> , 1958, that I last saw the deceased alive on <i>1 Nov</i> , 1958, and that death occurred at <i>11 AM</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Berkeley, Md</i>	DATE SIGNED <i>11/3/58</i>
ACTUAL SIGNATURE <i>James B Collins</i>		PHYSICIAN'S NAME (Type) <i>James B Collins M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 3 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Odd Fellows</i>	22d. LOCATION (City, town, or county) <i>Bethesda</i>	(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>NATSON-GRAY</i>	ADDRESS <i>Frankford Delmar</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 10 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13136

CERTIFICATE OF DEATH

13130

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Whaleyville</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		e. STREET ADDRESS <i>Whaleyville B.P.</i>		
f. IS RESIDENCE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Harold Lee Eshom</i>		First <i>Harold</i>	Middle <i>Lee</i>	
4. DATE OF DEATH <i>Nov. 18 1958</i>		Month <i>Nov.</i>	Day <i>18</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>March 9 1919</i>		9. AGE (In years (on birthday) yrs.) <i>39</i>	10. IF UNDER 1 YEAR Months <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own farm</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Selby Eshom</i>		
14. MOTHER'S MAIDEN NAME <i>Eva Kate Hudson</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. <i>217-14-8630</i>		17. INFORMANT <i>Mrs Emma Eshom Whaleyville</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>162.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>generalized metastatic Carcinoma 2 mos.</i> <i>Bronchogenic Carcinoma 2-3 mos.</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>August</i> , 1958, to <i>November</i> , 1958, that I last saw the deceased alive on <i>Nov. 18</i> , 1958, and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert A. Grub</i> PHYSICIAN'S NAME (Type) <i>ROBERT A. GRUBB</i>		ADDRESS (Street, city or town, state) <i>Berlin, Md.</i>		DATE SIGNED <i>11/19/58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/26/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Redman</i>	22d. LOCATION (City, town, or county) <i>Whaleyville, Del.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Peter Whaley Whaleyville, Del.</i>		ADDRESS <i>Peter Whaley Whaleyville, Del.</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 21 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Carroll S. Knapp</i>

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STATE OF CALIFORNIA - DEPARTMENT OF REVENUE - SACRAMENTO, 19

CELESTINE DE GEAH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13137

CERTIFICATE OF DEATH

13131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin Rural		c. LENGTH OF STAY IN 1b all her life						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Elsie		First May	Middle Fassett	4. DATE OF DEATH 11	Month 19	Day 19	Year 1958	
5. SEX FM	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 10, 1901	9. AGE (In years lost birthday) 57 yrs.	IF UNDER 1 YEAR Months 57	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory		10b. KIND OF BUSINESS OR INDUSTRY Canning		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles E. Brittingham				14. MOTHER'S MAIDEN NAME Jennie Robbins				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-24-2388		17. INFORMANT William W. Fassett, Berlin, Md., Route #3		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Hypertension		Congestive Heart Failure DUE TO Hypertension		INTERVAL BETWEEN ONSET AND DEATH 24 hrs				
(c) DUE TO Hypertension		Cardio vascular disease 3 yrs gone						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank J. Stewart, Jr.</i>		ADDRESS (Street, city or town, state) M.D. <i>Berlin, Md.</i>						DATE SIGNED 11/24/58
PHYSICIAN'S NAME (Type) Dr. I. V. Sully, M.D.		Berlin, Md., Route # 3						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-1958		22c. NAME OF CEMETERY OR CREMATORIUM Germantown Cemetery		22d. LOCATION (City, town, or county) Berlin, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 28 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

CERTIFICATE OF DEATH

DEATH CERTIFICATE

NAME

DEATH DATE

AGE AT DEATH

SEX

CAUSE OF DEATH

DEATH PLACE

DEATH TIME

DEATH DATE

DEATH TIME

DEATH PLACE

DEATH DATE

DEATH TIME

NAME

AGE

SEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Film G236 items 4 & 9 12/2/58 88
 13138 **CERTIFICATE OF DEATH** 13132
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEWARK		b. COUNTY WORCESTER	
c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X NEWARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS R.R.D. CEDARTOWN	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE W. JOHNSON		First	Middle
4. DATE OF DEATH November 22, 1958		Month	Day Year
5. SEX M		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Unknown		9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) NEWARK MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME REUBEN R. JOHNSON		14. MOTHER'S MAIDEN NAME SARALIZIE JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mr. OTHO JOHNSON, NEWARK, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Cerebral Apoplexy My peritonitis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 58 11-23 58		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1 , 19 58 , to 11-23 , 19 58 , that I last saw the deceased alive on 11-23 , 19 58 , and that death occurred at 58 11-23 58 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) EDGERTON E. SCHOTT BERLIN MD. DATE SIGNED	
ACTUAL SIGNATURE EDGERTON E. SCHOTT BERLIN MD.			
PHYSICIAN'S NAME (Type) EDGERTON E. SCHOTT BERLIN MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/25/58	
22c. NAME OF CEMETERY OR CREMATORIAL CEDAR CHAPEL		22d. LOCATION (City, town, or county) NEWARK MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Anna D. Burbage Berlin Md.		ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 28 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Francis	

WISCONSIN STATE BOARD OF HIGHER EDUCATION
CERTIFICATE OF DEATH

REG. NO. 100

REG. NO. 100

REG. NO. 100

REG. NO. 100

REG. NO. 100
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REG. NO. 100

REG. NO. 100

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REG. NO. 100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13139

CERTIFICATE OF DEATH

Reg. Dist. No.

13133

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Dorchester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN lb <i>Cambridge</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4 Peachblossom St.</i>		d. STREET ADDRESS <i>4 Peachblossom St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Melvin</i>	Middle <i>Jones</i>	Last <i>Jones</i>
4. DATE OF DEATH <i>Nov. 10 1958</i>	Month <i>Nov.</i>	Day <i>10</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <i>June 3, 1920</i>	9. AGE (In years lost birthday) <i>38 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wire Cloth Belts</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James Jones</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> U.S. Army Unknown	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Melvin Jones Cambridge Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Coronary Occlusion.</i> DUE TO (c) <i>Atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i> <i>5 yrs</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/10/58</i> , 19, to <i>11/10/58</i> , 19, that I last saw the deceased alive on <i>11/10/58</i> , 19, and that death occurred at <i>12:45 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Bay St., Snow Hill, Md.</i> DATE SIGNED <i>11-11-58</i>	
ACTUAL SIGNATURE <i>Robert C. La Mar</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>Robert C. La Mar, M. D.</i>		22d. LOCATION (City, town, or county) <i>Cambridge Maryland</i> (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov. 12, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Dorchester Men. Park</i>	22d. REC'D BY REGISTRAR <i>Nov 14 '58</i> DATE
23. FUNERAL DIRECTOR'S SIGNATURE <i>LeCompte Funeral Service</i>		24b. REGISTRAR'S SIGNATURE <i>LeCompte Funeral Service</i>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13134

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Worcester	STATE	Md.
CITY (If outside corporate limits, write RURAL or and give nearest town)	MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town)	Worcester
TOWN	Length of Stay (in this place)	TOWN	Berlin
HOSPITAL OR INSTITUTION OR STREET ADDRESS	72 yrs	STREET ADDRESS	Flower Street
Flower St	Home	(If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First)	(Middle)	(Last)	(Month) (Day) (Year)
Laura		C. Pitts	November 20, 1958
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH
F	Col	W	May 27, 1886
9. AGE last birthday	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
72 yrs.	Domestic	Maryland	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Charles Brittingham	Maggie PURNELL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES?	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
(Yes, no, or unk.)	(If Yes, give war or dates of service)	RFD #3 Box 113 Clara Purnell Berlin, Md	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
443X	IMMEDIATE CAUSE (A)	4 days	
ANTECEDENT CAUSE(S) DUE TO		4 1/2 yrs.	
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO		Hypertension Cardio-vascular Disease	
(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4/8, 1957, to 11/15, 1958, that I last saw the deceased alive on 11/15, 1958, and that death occurred at 2:05 A.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
John J. Shultz, Jr. M.D.		11/22/58	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)
Burial	11/22/1958	Evergreen	Berlin
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	
DATE NOV 28 '58	John S. Kraus	Clinton F. Stewart, Salis M.D.	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the burial director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

13133 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			c. LENGTH OF STAY IN 1b 85 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 220 Walnut Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ESTELLE		First E.	Middle E.	Last POWELL	4. DATE OF DEATH Month November
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 3, 1873	9. AGE (In years last birthday) 85 yrs.	Day IF UNDER 1 YEAR Months Days Hours Min. 4, 19 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank J. Ross			14. MOTHER'S MAIDEN NAME Sarah M. Powell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs William Trader, Pocomoke City, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Uremia (b) Chronic Nephritis (c)					
INTERVAL BETWEEN ONSET AND DEATH 2 days years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 1. Bronchiectasis 2. Degenerative Heart Disease					
20a. ACCIDENT WAS UNDERRING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 345a
20f. (City or town) Pocomoke City	(County) Md.	(State) Md.			
21. I certify that I attended the deceased from Feb. 1949 to Nov. 4, 1958 , that I last saw the deceased alive on Nov. 4, 1958 , and that death occurred at 345a , M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) 302 Market St., Pocomoke City, Md.					
DATE SIGNED 11-5-58					
ACTUAL SIGNATURE Charles W. Trader		PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-58		22c. NAME OF CEMETERY Bethany Methodist	
22d. LOCATION (City, town, or county) Pocomoke City, Maryland		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. D. Watson		ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR NOV 7 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Tracy	

STATE OF HAWAII - DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

WILLIAM

Travis (1981)

DEATH CERTIFICATE

9/10/01

DEATH CERTIFICATE

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

13141 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13135

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md						
b. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town) Ocean City	c. LENGTH OF STAY IN lb 60 years	b. COUNTY Wor	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RTI Ocean City, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) Edwin		First Edwin	Middle DeWay					
4. DATE OF DEATH Nov 30 1958	Last Taylor	Month Nov	Day 30	Year 1958				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1898	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) Ocean City, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME L. Hazzard Taylor		14. MOTHER'S MAIDEN NAME Angeline Baker		Address Berlin, Md.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 216-09-7786		17. INFORMANT Mrs Anna Burbage		INTERVAL BETWEEN ONSET AND DEATH INSTANT.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		CORONARY Occlusion, Acute arteriosclerotic CVD		8 years.		
DUE TO (b)		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260 Diabetes mellitus		90%.				19. WAS AUTOPSY PERFORMED? NO		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 90%.						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) BERLIN	(County) Md	(State) Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE F J Townsend Jr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED DEC 1, 58.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/58	22c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN	22d. LOCATION (City, town, or county) BERLIN	(State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage Berlin Md.		ADDRESS ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 3 '58	24b. REGISTRAR'S SIGNATURE Charles E. Krause				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13137

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WORCESTER		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY		c. LENGTH OF STAY IN 1b 7 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		d. STREET ADDRESS 209 Collins St		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 500 Philadelphia Ave				d. STREET ADDRESS 209 Collins St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Florence	Middle D.	Last 111	4. DATE OF DEATH	Month 11	Day 26	Year 1958	
5. SEX F	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1867	9. AGE (In years last birthday) 91	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HENRY Dashiell		14. MOTHER'S MAIDEN NAME Priscilla Wart						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-24-5751		17. INFORMANT JACK Smack - 500 Phila, Ave, OCEAN CITY, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x		DUE TO Chronic				INTERVAL BETWEEN ONSET AND DEATH 1 w/e		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Arteriosclerotic Cardio renal disease				5 yrs		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Ocean City, Md		(County) 27 Nov 58 (State)
21. I certify that I attended the deceased from Sept , 1958, to Nov 26 , 1958, that I last saw the deceased alive on 26 Nov 58 , 1958, and that death occurred at 6:45 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Ocean City, Md 27 Nov 58.		DATE SIGNED
ACTUAL SIGNATURE W. Thomas		M.D.						
PHYSICIAN'S NAME (Type) W. Thomas								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-28-58		22c. NAME OF CEMETERY OR CREMATORIY EBENEZER CEMETERY		22d. LOCATION (City, town, or county) Snow Hill, Md		(State)
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart FUNERAL Home, Salisbury, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

1960

DECEASED PERSON'S NAME

DEATH DATE

DEATH PLACE

DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13143 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13138

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Pocomoke City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROY Middle LEE Last WARD		4. DATE OF DEATH Month November Day 21 Year 1958	
5. SEX Male White		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Nov. 15, 1958 9. AGE (in years last birthday) yrs. 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas E. Ward		14. MOTHER'S MAIDEN NAME Susan Jane Tarr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. --- 17. INFORMANT Thomas E. Ward, Pocomoke City, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9240 DUE TO Asphyxia			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Suffocation in bed		short	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suffocated	
20c. TIME OF INJURY Month, Day, Year Hour 10 a.m. 11/21/58 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Worcester	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED 11/21/58	
ACTUAL SIGNATURE N. E. SARTORIUS, SR.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-58 22c. NAME OF CEMETERY Beth Eden Cemetery 22d. LOCATION (City, town, or county) Rural Pocomoke City, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Sartorius		ADDRESS Pocomoke City, Md. 24a. REC'D BY REGISTRAR NOV 24 '58 24b. REGISTRAR'S SIGNATURE Orville S. Tamm	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

